OAK PARK PEDIATRICS

Patient Registration Form

Patient Name (Last, First)**:** **DOB:**		Male Female Other
Parent # 1 Name (Last, First)**:** **DOB:**		**Occupation:**
Address: **City/State** **Zip code:**		**Parent Mobile #:**
Employer:		**Home #:**
Email:		
Parent # 2 Name (Last, First)**:** **DOB:**		**Occupation:**
Address: **City/State** **Zip code:**		**Parent Mobile #:**
Employer:		**Home #:**
Email:		
Child's parents are: __Married __Separated __Divorced __Other:_____		
Emergency Contact/Relationship:		**Phone #:**
Primary Language(s) Spoken at Home: English Other:		
Ethnicity: __Asian White __ Hispanic/Latino __American Indian __ African American __Pacific Islander __Other		

Siblings Name (Last, First)	**Birth Date**	**Male Female Other**

Social History/ Safety Issues

Who lives in the home? _____

Do any household members smoke? __Yes __No

Do you have a gun in your home? __Yes __No Are they locked up? __Yes __No

Are there any pets in your home? __Yes __No (Specify:)_____

Does your child attend daycare/preschool/school? __Yes __No Grade:_____ School Name:_____

Any concerns about school performance? __Yes __No Specify:_____

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Birth History

Delivery Hospital: _____ Your Ob: _____

Were there any problems with the pregnancy? __No __Yes (Please Specify) _____

Was the baby full term____ or premature? ____ If so, how early _____

NICU: __Yes __No If yes, reason for NICU hospitalization: _____

Delivered by: __ Vaginal Birth __ Caesarian (Please explain why:)_____

Birth Weight: _____ Birth Length: _____ Passed Hearing Screen? __Yes __No

Patient Medical History

Allergies: __Yes __No If yes; specify_____

Does your child Take: __Vitamins __Supplements __Special Diet __ Medications

If yes, please explain:

_____

_____

Has your child had any surgeries? __No __Yes; If yes, please list year and type of surgery below:

_____

_____

Has your child had any **hospitalizations/Illnesses/Injuries**? __No __Yes; If yes, please list year and explain below:

_____

_____

Has your child seen any specialists/therapists? __No __Yes; If yes, please list doctor(s), and reason for specialty care:

_____

_____

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Please check below if your CHILD has/has any of the following?

☐ ADD/ADHD	☐ Developmental Delay	☐ Migraines	☐ UTI/Kidney Infection
☐ Allergy(eyes, nose, skin)	☐ Food allergies	☐ Obesity	☐ Other:
☐ Anemia	☐ Frequent ear infections	☐ Frequent Infections	
☐ Asthma	☐ Hearing Problems	☐ Seizures/epilepsy	
☐ Autoimmune condition	☐ Heart Condition	☐ Skin problems	
☐ Bleeding Problems	☐ High Cholesterol	☐ Snoring	
☐ Constipation/diarrhea	☐ Immune Problems	☐ Speech Difficulty	
☐ Eczema	☐ Gastroesophageal reflux	☐ + TB test	
☐ Depression/Anxiety	☐ Learning Disability	☐ Thyroid Problems	

Family History (Please specify which family member)

☐ Alcoholism/Drug abuse:	☐ Thyroid disease (specify):
☐ ADHD/Learning Disabilities:	☐ High Cholesterol:
☐ Asthma:	☐ High Blood Pressure:
☐ Allergies/ Hay fever: ☐ Food allergy:	☐ Congenital hearing loss:
☐ Bleeding/Clotting problems:	☐ Heart attack (before 50):
☐ Depression/Mental illness/ anxiety:	☐ Heart disease/Sudden unexplain death before age 50:
☐ Diabetes (specify):	☐ Inherited genetic disease/birth defects; (specify)
☐ Eczema:	
☐ Kidney Disease:	☐ Other:
☐ Seizures/Febrile seizures:	